



**Texas Department of Insurance**  
**Division of Workers' Compensation**  
Medical Fee Dispute Resolution, MS-48  
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### PART I: GENERAL INFORMATION

Requestor Name and Address:  TEXAS ORTHOPEDIC SURGERY CENTER 4700 SETON CENTER PARKWAY SUITE 100 AUSTIN TX 78759	MFDR Tracking #: M4-03-7594-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #:  ZURICH AMERICAN INSURANCE CO Box #: 19	Date of Injury:
	Employer Name:
	Insurance Carrier #:

### PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

**Requestor's Rationale for Increased Reimbursement:** "Since there is no MAR for ASC's we will accept a fair & reasonable payment established by what the majority of payors remit on routine basis. Our records will reflect that a large majority of our payors remit 85% or more of billed charges; therefore, we can establish that a F&R amount for procedures performed in our area is at least 85% of billed charges, and we hereby request that the amount in dispute be paid."

**Principal Documentation:**

1. DWC 60 Package
2. Medical Bill(s)
3. EOB(s)
4. Total Amount Sought - \$2,814.00

### PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

**Respondent's Position Summary:** "Carrier paid \$612.00 of a \$4,030 bill leaving \$2,814.00 in dispute. The rate of reimbursement for ASCs is not governed by a fee guideline. The reimbursement methodology is neither specified in the *Acute Care Inpatient Fee Guideline* for hospitals nor for is it specified in the *Medical Fee Guideline*. Accordingly, services are to be reimbursed at a fair and reasonable rate." "Carrier accordingly developed and consistently applies a methodology (Medicare Group 3 rates plus 20%) to determine fair and reasonable reimbursement amounts to insure that similar procedures provided in similar circumstances receive similar reimbursement."

**Principal Documentation:**

1. Response Package

### PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
10/7/2002	M	29879	\$2,814.00	\$0.00
			<b>Total Due:</b>	<b>\$0.00</b>

### PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code § 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Medical Reimbursement*, effective May 2, 2006 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on June 9, 2003. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on June 25, 2003 to send additional documentation relevant to the fee dispute as set forth in the rule.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code:
  - M-No MAR.
2. Division rule at 28 TAC §134.401(a)(4), effective August 1, 1997, states “Ambulatory/outpatient surgical care is not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific types of reimbursements.”
3. This dispute relates to ambulatory surgical care services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 2, 2006, 31 TexReg 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers’ compensation health care network shall be made in accordance with subsection §134.1(d) which states that “Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available.”
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. Division rule at 28 TAC §133.307(g)(3)(B), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including “a copy of any pertinent medical records.” Review of the submitted evidence finds that the requestor has not sent a copy of any / all pertinent medical records. The Division concludes that the requestor has not provided documentation sufficient to meet the requirements of Division rule at 28 TAC §133.307(g)(3)(B).
6. Division rule at 28 TAC §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include “how the submitted documentation supports the requestor position for each disputed fee issue.” Review of the submitted documentation finds that the requestor did not state how the submitted documentation supports the requestor's position for each disputed fee issue. The Division concludes that the requestor has not provided documentation sufficient to meet the requirements of Division rule at 28 TAC §133.307(g)(3)(C)(iv).
7. Division rule at 28 TAC §133.307(g)(3)(D), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement.” Review of the submitted documentation finds that:
  - The requestor's rationale for increased reimbursement from the *Table of Disputed Services* states that “Since there is no MAR for ASC's we will accept a fair & reasonable payment established by what the majority of payors remit on routine basis. Our records will reflect that a large majority of our payors remit 85% or more of billed charges; therefore, we can establish that a F&R amount for procedures performed in our area is at least 85% of billed charges, and we hereby request that the amount in dispute be paid.”
  - The requestor's rationale for increased reimbursement requests payment of 85 percent of total charges, however, the requestor does not discuss or demonstrate how payment of 85 percent of total charges would result in a fair and reasonable reimbursement.
  - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
  - The requestor does not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, provide for payment that is not in excess of a fee charged for similar treatment of an injured individual of an equivalent standard of living, consider the increased security of payment, or otherwise satisfy the requirements of Texas Labor Code §413.011(d) or Division rule at 28 TAC §134.1.The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.
8. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(g)(3)(B), §133.307(g)(3)(C), and §133.307(g)(3)(D). The Division further

concludes that the requestor failed support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

#### PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code § 413.011(a-d), § 413.031 and § 413.0311  
28 Texas Administrative Code §133.1, §133.307, §134.1, §134.401  
Texas Government Code, Chapter 2001, Subchapter G

#### PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

#### DECISION:

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

**July 26, 2010**

\_\_\_\_\_  
Date

#### PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**